THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-2807.M5

MDR Tracking Number: M5-05-0008-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on August 30, 2004.

In accordance with Rule 133.307 (d), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 08-30-04, therefore the following date(s) of service are not timely: 05-21-03, 05-23-03 and 08-26-03.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic procedures, therapeutic activities, massage, manual therapy technique, electrical stimulation unattended, ultrasound, neuromuscular re-education from 09-19-03 through 03-03-04 that were denied with "V" were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 09-21-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Max. Allowable Reimbursement)**	**Reference**	**Rationale**
12-15-03	99214	$99.00	$0.00	K	$98.62	Medicare Fee Schedule	CPT code 99214 is used to report evaluation and management services provided in the physician's office or in an outpatient or other ambulatory facility. This service was not rendered at one of these facilities therefore, no reimbursement recommended.
12-16-03	97124	$28.00	$0.00	F	$28.00	Medicare Fee Schedule	Requestor submitted relevant information to support services billed. Recommend reimbursement of $28.00.
12-18-03	97110 97140 97124 G0283	$35.00 $34.00 $28.00 $16.00	$0.00	F F G F	$34.41 $32.65 $27.25 $14.91	Medicare Fee Schedule Rule 133.304	See rationale below for CPT code 97110. Requestor submitted relevant information for CPT codes 97140 and G0283 to support services

						(c)	billed. Recommend reimbursement of $47.56. Per Rule 133.304 (c) carrier didn't specify which service CPT code 97124 was global to, therefore it will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of $27.25.
12-22-03	97110 97140 97124 G0283	$35.00 $34.00 $28.00 $16.00	$0.00	F F G F	$34.41 $32.65 $27.25 $14.91	Medicare Fee Schedule Rule 133.304 (c)	See rationale below for CPT code 97110. Requestor submitted relevant information for CPT codes 97140 and G0283 to support services billed. Recommend reimbursement of $47.56. Per Rule 133.304 (c) carrier didn't specify which service CPT code 97124 was global to, therefore it will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of $27.25.
TOTAL		$244.00					The requestor is entitled to reimbursement of $177.62.

Rationale for CPT code 97110 - Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 12-16-03 through 12-22-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 11th day of November 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

SECOND AMENDED DECISION

Date: October 29, 2004

RE:
MDR Tracking #: M5-05-0008-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Letter from ___ 8-26-04
- Letter from ___
- Physical therapy notes: 2-27-03-12-15-03
- MRI brain 8-6-02
- Notes from ___ 8-12-02
- Notes from ___
- Notes from ___

Submitted by Respondent:

- Retrospective review: 11-11-02
- Preliminary Physical therapy review: 9-3-03, 5-2-03
- Notes from ___
- Notes from ___
- ___ notes
- Notes from ___
- Notes from ____

Clinical History

This is a 52 year old female with repetitive injury claim ___. Complaining of pain from the shoulders to the fingertips. EMG and NCV studies were negative. Surgery on the left upper extremity by ___ of ____ was performed on 2-3-03: left carpal tunnel release and ulnar nerve transposition. The same surgery was done on the right upper extremity on 6-9-03. The patient had extensive physical therapy after both procedures. Therapy was from 2-27-03 to 3-3-04.

Requested Service(s)

97110 – Therapeutic Procedures, 97530 – Therapeutic Activities, 97124 – Massage, 97140 – Manual Therapy Technique, G0283 – Electrical Stimulation Unattended, 97035 – Ultrasound, 97261 – Manipulation, 97112 – Neuromuscular Re-education from 9-19-03 to 3-3-04.

Decision

I agree with the insurance carrier that the services from 9-19-03 through 3-3-04 are not medically necessary. These include CPT Codes 97110, 97530, 97124, G0283, 97140, 97035, 97261, and 97112.

Rationale/Basis for Decision

The surgery performed, carpal tunnel release and ulnar nerve transposition are not surgeries that require long or intensive rehabilitation, most can be done with a home exercise program. The usual range of return to activities for these surgeries is 18 to 38 days with an extreme of 54 days. These followed extensive rehabilitation visits that were approved. The therapy visits requested far exceed the expected recovery period from the surgeries that were performed.